fill gaps, so that rule making can go forward.
Q Thank you. I want to now turn to how it is that you used -- if we could go back to 2262, you said that you used Dr. Moolgavkar's benchmarks. I want to talk about how it is that you applied or used those benchmarks by reference to the cumulative doses that you determine in part on the basis of Dr. Lees' with an S work. And I want to show you Exhibit 2285 and ask you whether this would assist you in explaining to the Court the comparison that you did. The answer to that is yes or no.
A Yes, I think it will assist us.
Q Okay, so now could you explain how -- what it is that is reflected in 2285?
A Yes, the values that we saw earlier and which are displayed here as the dose cumulative exposure values can now be compared to these benchmarks to give us some guidance as to what they mean. We see for the A category an accedence of these conservative screens of the 15. We see for the B category an accedence of no benchmark. For the C category the maximum is a 12, so it's below the 15. It's in the zone of inference. It's above the relative risk, a modeled calculation for Libby Fibers, but it's -- well, let's move on to D. D and E are very small exposures relative to the benchmarks, and they are under all of the benchmarks.
Q Okay. This compare --

A And I should note that the 3.2 number is a mixed fiber number that includes chrysitolite, which is the most potent of the fibers and is not in the Grace product, so I don't take that benchmark to be particularly useful.

Q That's the one that's --

THE COURT: Which one? I'm sorry. Which one. I'm sorry?

THE WITNESS: Three point two.

THE COURT: Point two.

THE WITNESS: It's referred to as meso-relative risk to mixed fibers.

THE COURT: Okay.

THE WITNESS: My understanding from speaking with Dr. Moolgavkar is that's taken from --

MR. MULLADY: Objection, Your Honor.

THE WITNESS: -- an EPA --

MR. MULLADY: Objection, Your Honor, the witness is about to tell us about a conversation she had with Dr. Moolgavkar about these fiber concentrations. That's hearsay.

THE COURT: She is, but --

MR. BERNICK: No, it --

THE COURT: -- Dr. Moolgavkar's already made that same statement yesterday on the stand.

MR. BERNICK: Right, but it's -- she's an expert.

THE COURT: He also testified to that same fact on

the stand yesterday. The record will substantiate that. He made the same statement on the stand yesterday.

MR. BERNICK: Right.

BY MR. BERNICK:

Q Just to review briefly, we have marked here the 2.8, which he said came from the auto workers study or the risk was not observed, the relative risk calculation -- relative risk of 2 with respect to mixed fibers, the 3.2, the working lifetime exposure, the OSHA fell 4.5, the relative risk of 2 for -- based on modeling for Libby fibers and meso, 15 which is the lowest observed average exposure for meso, and then ranging way up to asbestosis threshold, chrysotile, relative risk of 2 and the like. Now, does Exhibit 2285 accurately summarize the comparative data that you used in connection with benchmarking the dose -- the cumulative doses with respect to the five categories?

A Yes, it does.

Q I want to turn to ask you and show you 2286. Could you explain, based upon the comparison that you did, what determinations you made with respect to the exposures as determined in accordance with your risk assessment? What assessment did you make with respect to the exposures of people who worked in occupations A, B, C, D, and E? What decision or what determination did you make?

A Well, I found unequivocally that people in Categories B,

D, and E are well below all of the benchmarks and need not be considered further. The Categories A and C claimants I have suggested should be further evaluated despite the fact that the C category is below the observed benchmark, and they have passed through -- if we want to call this a screening exercise, those two categories have passed through for further analysis but not B, D, and E.

Q I want to take the last step now that we see on the board, 2296, which we see it's called Risk for Claimants. Why is it that risk assessment goes beyond the comparison of calculated doses in benchmarks? Why is it that the risk assessment takes another step?

A I'm not sure I understand the question.

Q Yes. Well, why do we have another step to take here?

A Oh.

Q Why another step?

A Well, I mean the important issue, as I understand it, is what are the merits of these claims going forward, and the information that I have now provided, as I understand it, will go into a claims review analysis for further evaluation. So the results of this analysis now go to the claims reviewers and Dr. Florence.

Q So we're talking about a risk for a population of people.

A That's right.

Q Okay. Now, in order to get into this area could you tell

the Court whether or not at your direction the PIQs -- a certain number of PIQs and a certain number of closed claims were reviewed?

A Yes, they were.

Q Okay, and showing you 2289, does this reflect -- 2289 first. Does this reflect the claims that were reviewed by people in your organization at your direction for purposes of figuring out what categories they belong?

A Yes.

Q Okay, and we have 15 hundred 96 mesothelioma claims, 32 lung cancer claims, 115 laryngeal cancer claims, 152 non-malignant disease claims, and then with respect to the closed claims, 350 mesothelioma claims, is that right?

A That's correct.

Q Okay. Now was there a procedure -- were there procedures established for purposes of this review?

A Yes, there were very strict procedures established with the team who did the review?

Q Showing you 2288, does this slide -- would this slide assist you in explaining the procedures or the steps that were taken in order to conduct this review?

A Yes, it does. We first needed to and did design a protocol to insure the proper assignment of claimants to the nature of exposure categories that would be consistent with Dr. Lees' definitions of exposure.

Q Okay. Let's -- Dr. Lees' defined the categories on the basis of those definitions looked for corresponding industrial hygiene data, and then in order -- and then in doing the claims review to find out what categories people belonged in, tell us why it was important for the same definitions to be used; that is, not just the definitions that somebody else might think of like a claimant or a worker or anybody, but why was it important to use Dr. Lees' definitions in reviewing the claim files?

A Because we were assigning these claimants to a nature of exposure category, and he had defined that category and collected the data, analyzed the data, and presented the data. So the two had to mesh. They had to be identical, as close as we could get them.

Q Okay. Why don't you continue to go on and talk about the steps that were undertaken thereafter in connection with the review?

A Well, next the review team was identified, obviously choosing people with appropriate experience and credentials. We established training sessions. We established quality control procedures. We had double review. And the actual claims review proceeded along the following lines. Obviously, the claims were inconsistent, and there were times when things were not quite as simple as other times, but we, first of all, accepted the self-identified claimants. If they checked the